HAWAII STATE MEDICAID PROGRAM
P.O. BOX 700190, KAPOLEI, HI 96709-0190
FAX: CSO - 208 PROCESSING (808) 692-8131
FAXED REQUESTS NEED NOT BE MAILED

PRIOR AUTHORIZATION REQUEST FOR AIR TRANSPORTATION, LODGING, MEALS AND GROUND TRANSPORTATION

INCOMPLETE FORMS WILL BE RETURNED

☐ Regular
☐ Urgent
☐ Emergent

PRINT CLEARLY AND LEGIBLY

RECIPIENT INFORMATION

1. Recipient's Medicaid ID No.	2. Recipient's Name (Last, First, Middle)	3. Sex ☐ M ☐ F	4. Date Of Birth (MM/DD/YYYY)

5. Mailing Address

6. City, State, Zip Code	7. Contact Person	8. Day Time Phone Number

REFERRING PHYSICIAN INFORMATION

9. Physician Name (Last, First, Middle)	10. Provider ID No.	11. Phone No.	12. Fax No.

13. Physician Signature	14. Contact Person At Office	15. Date

APPOINTMENT INFORMATION

16. Treatment/Description Of Medical Service

17. Medical Reason For Treatment

18. Prior Authorization Required? ☐ Yes ☐ No ☐ Unknown	19. Can The Procedure Be Done On Your Island? ☐ Yes ☐ No	If No, Explain Why:

Appointment Details

20. Rendering Physician/Hospital	21. Rendering Provider ID No.	22. Rendering Provider Phone No.
23. Scheduled Date Of Medical Service	24. Start Time (Date/Time Recipient Must Be Present)	25. End Time (Date/Time Of Release)
26. Physical Address Of Medical Service		

Appointment Details

27. Rendering Physician/Hospital	28. Rendering Provider ID No.	29. Rendering Provider Phone No.
30. Scheduled Date Of Medical Service	31. Start Time (Date/Time Recipient Must Be Present)	32. End Time (Date/Time Of Release)
33. Physical Address Of Medical Service		

TRAVEL REQUEST INFORMATION

34. Departure Date	35. Return Date	36. Medical Reason For Stay Longer Than 1 Day

37. Departure City/Airport	38. Arrival City/Airport	39. Type Of Ticket (One-Way And/Or Round-Trip) ☐ One Way ☐ Round Trip

40. Attendant Required? ☐ Yes ☐ No	41. Name Of Adult Attendant (As Listed On Valid Picture ID)	42. Medical Reason For Attendant

43. Oxygen Required? ☐ Yes ☐ No If Yes, ☐ Nasal or ☐ Mask; O_2 Flow Rate_____	44. Wheelchair Required? ☐ Yes ☐ No If Own Wheelchair, What Type:	45. Other Special Travel Needs

46. Ground Transportation Required? ☐ Yes ☐ No	47. Lodging Required? ☐ Yes ☐ No	48. Meals Required? ☐ Yes ☐ No

THIS SECTION TO BE COMPLETED BY THE MED-QUEST DIVISION

49. Determination: ☐ Incomplete (See Comments) ☐ Denied (See Comments) ☐ One-Way ☐ Round-Trip	Attendant/Companion: ☐ Yes ☐ No	Ground Transportation: ☐ Yes ☐ No	Lodging: ☐ Yes ☐ No	Meals: ☐ Yes ☐ No	Special Travel Needs: ☐ Yes (see comments) ☐ No	50. Control #

51. Section/Unit #	52. Worker's Name	53. Worker's Phone	54. Worker's Fax

55. Comments

56. DHS Medical Consultant Signature	57. Date

Non-Emergent and Non-Urgent Conditions: If within 14 days fax to CSO - 208 Processing (808)692-8131
Otherwise mail to Med-QUEST Division, CSO - 208 Processing
Emergency or Urgent Conditions: P.O. Box 700190, Kapolei, HI 96709-01901